

MATERNAL CHILD HEALTH FAMILY HISTORY

Client Name _____

DOB _____

CHILD'S HISTORY

Please check if your child has had any of the following

Abuse (physical, sexual, emotional)	Dental problems	Juvenile Rheumatoid Arthritis/	RSV
Adopted - hx unknown	Depression	Joint problems	Rubella
Anemia/blood problems	Developmental Delays	Lead Poisoning	School/learning problems
Asthma	Diabetes	Learning problems	Sickle Cell
Autism	Drug Allergy	Measles	Sleeping problems
Bed Wetting	Ear Infections	Meningitis	Speech problems
Behavior problems	Eczema	Mental illness	Strep Throat/Scarlet Fever Hx
Birth defects	Encephalitis	Metabolic disease	Surgeries (list on back)
Cancer	Epilepsy/Seizures	Mumps	Temper Tantrums
Cerebral Palsy	Feeding problems	Muscular Dystrophy	Thyroid problems
Chicken Pox	Food Intolerance	Myringotomy (Tubes in ears)	Tires Easily
Constipation/Bowel problem	Fractures	Overnight hospitalizations	Tonsillitis - Hx of
Cystic Fibrosis	Genetics/Inherited problem	PKU	Traumatic Injury
Death of a Family Member	Growth problems	Pneumonia	Urinary Tract Infection
	Hearing problems	Prematurity (_____ wks)	Vision problems
	Heart problems	Respiratory problems	Whooping Cough

FAMILY HISTORY

Please indicate the care giver or family member who has had any of the following conditions using the following code:

M=mother of child, F=father of child, S=sister of child, B=brother of child, GP = grandparent of child

Adopted and/or hx unknown	Cystic Fibrosis	Hemophilia/blood problems	Muscular Dystrophy
Allergy, Eczema, Hay Fever	Deafness/Hearing Loss	High Blood Pressure	PKU or Metabolic Disease
Anxiety	Death of Infant	Intestinal Disease	Sickle Cell Disease
Asthma/other lung problems	Depression	Juvenile Rheumatoid Arthritis	Speech problems
Autism	Diabetes	Kidney Disease	Stroke
Birth Defects	Disabilities	Lead Poisoning	Substance Abuse/Dependency
Blindness	Epilepsy/Seizures	Learning/School Problems	Thyroid Disease
Cancer	Fainting/Blackouts	Mental Illness	Tobacco Dependency
Cerebral Palsy	Genetics/Inherited problem	Mental Retardation	Tuberculosis
Child Abuse/Family Violence	Heart problems	Miscarriage/Still Birth	Vision problems
Chronic Illness/Disability			

See back for comments.

Completed by _____

Reviewed by/Date _____

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